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PUBLICATIONS OF THE OREGON STATE JOINT COMMITTEE
FOR HEALTH AND PHYSICAL FITNESS

Volume 1, Number 2 *Revised 1944*

OREGON MANUAL

for the Use of

THE SCHOOL HEALTH RECORD CARD

Issued by REX PUTNAM, Superintendent of Public Instruction

Oregon Manual for the Use of the School Health Record Card

Prepared under the direction of the

Oregon State Joint Committee for Health and Physical Fitness

Issued by

REX PUTNAM

Superintendent of Public Instruction

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FOREWORD

To

Oregon Manual for the Use of the School Health Record Card

This manual and the Health Record Card were prepared by the School Health Record Committee, a special subcommittee of the standing committee on Health Service of the State Joint Committee on Health and Physical Fitness. The members of that committee were:

Lucile Perozzi, Director, Division of Public Health Nursing, Oregon State Board of Health, Chairman.

V. D. Bain, Director of Curriculum and Elementary Education, State Department of Education.

Mrs. Nova Young, Supervising Nurse, Marion County Health Department.

Mrs. Anne Leffingwell, Supervising Nurse, Lane County Health Department.

Ethel Mealey, Consultant in Health Education, Oregon State Board of Health.

J. C. Haldeman, M. D., Medical Director, Wasco County Health Department.

Laurence C. Moffitt, Lane County School Superintendent.

T. F. Brumbaugh, Wasco County School Superintendent.

The manual has been revised under the direction of the executive committee of the State Joint Committee. Members of the executive committee are:

Elnora Thomson, Director of Nursing Education, University of Oregon Medical School, Chairman.

Dr. R. W. Leighton, Dean, School of Physical Education, University of Oregon.

Dr. Harold M. Erickson, Assistant State Health Officer, Oregon State Board of Health.

Ethel Mealey, Consultant in Health Education, Oregon State Board of Health.

Dr. V. D. Bain, Assistant Superintendent, State Department of Education.

Joy Hills, Supervisor, Curriculum and Publications, State Department of Education.

Editing of the manual was done by the editing committee of the State Joint Committee. The members of this committee are:

H. S. Hoyman, Assistant Professor of Physical Education, University of Oregon.

Ethel Mealey, Consultant in Health Education, Oregon State Board of Health, Chairman.

Joy Hills, Supervisor, Curriculum and Publications, State Department of Education.

INTRODUCTION

It is now generally agreed that there are many groups and many individuals who have an interest in and a responsibility for the health of the pupil during his entire school life. This includes the parents, the school administrator, the classroom teacher, and special teachers; the public health nurse and the health officer; the private physician and the private dentist; personnel associated with special programs such as nutrition and recreation; and volunteer groups, social and civic. Each person and group has a skill, a strategic opportunity, responsibility, and contribution which must be recognized and utilized in order to have an effective health program. For example: The teacher has an excellent opportunity to observe pupils during the entire school day for many days in succession; the public health nurse has the opportunity to visit the homes and to confer with parents, pupils, teachers, school administrators, and physicians; the physician has professional skill in examining pupils and an opportunity to give information during the examination. Through the cooperative efforts of these individuals and groups an effective understanding of the pupil can be developed.

The Oregon State Joint Committee for Health and Physical Fitness, whose membership is composed of representatives from the State Board of Health, the State Department of Education, the State System of Higher Education, and organized professional groups, is one of the agencies most concerned. The school is, of course, vitally concerned with such a program—and many schools have developed health programs. However, over a period of years it has become apparent to persons working with these programs that solutions were needed to several problems such as:

1. How may the specific skills of each person interested in the pupil's development be utilized?
2. How can the teacher be informed intelligently about the physican's recommendations, nurse's home visits, follow-up, and the health status of each pupil?

3. How can the information which each interested person has be shared?
4. How can pupils in need of a more thorough examination be selected?
5. How can a definite basis for bringing together teachers, nurses, parents, and the physician be established and the time of each person be conserved?
6. How can all persons concerned know what is "happening" to the pupil?

PURPOSES
OF THE OREGON SCHOOL HEALTH RECORD CARD

The Oregon School Health Record Card is one means of answering the questions presented in the introduction:*

It brings together in one record significant information considered essential to planning for the welfare of the individual pupils. This information is furnished and used by the parent, the teacher, the public health nurse, and the examining physician.

It is a tool to assist the teacher in making and recording her observations of the pupils so that she has definite information for herself, the nurse, the physician, and the parent.

It is the basis for planned conferences: teacher-nurse, parent-nurse, nurse-physician, parent-teacher-physician-nurse.

It is a means of assisting in selecting from any grade pupils who apparently are in immediate need of a health examination given either by the family physician or the examining physician in the school.

It is one means by which the teacher is informed about the physician's recommendation, the nurse's home visits, the follow-up, and the health status of each pupil.

It is a device for sharing information.

It reduces duplication in recording to a minimum.

It is a cumulative record beginning with the time when the pupil enters the school system, and passes with the pupil from grade to grade including the high school.

It provides for unity of purpose and unity of effort among all persons concerned with the health and well-being of the pupil.

* The Health Record Card with the manual is only one activity or phase of the entire health program for the pupil in school. Additional information about the Health Services may be found in "Health Services for the School-Age Child", prepared under the direction of the Oregon State Joint Committee for Health and Physical Fitness.

HOW TO USE
THE OREGON SCHOOL HEALTH RECORD CARD

I. The School Administrator's Participation

The school administrator must be convinced of the value of the card and must help his staff understand its value and use. He should:

A. Work out a plan for its use

1. Provide a card for each pupil in the elementary and high schools.
2. Provide a filing case for each teacher. The card is a school record and is to be filed with the teacher who is responsible for its use.
3. Delegate some person in the elementary and high schools where the pupil has more than one teacher to be responsible for recording observations and filing the card. This person may be the physical education teacher, home room teacher, or counselor. The important thing is to delegate the authority to a trained and interested teacher.
4. Provide a plan by which the teacher may participate in at least a few health examinations given in the school.
5. Provide a time and a place for the teacher-nurse conference.
6. Dispense with all other health records
   a. Pupil Health Inspection Record.
   b. Health data on the Oregon Elementary Pupil Cumulative Record card and folder.
7. Transfer the Health Record Card with scholastic records at the close of the school year, or whenever the pupil transfers to another teacher or school within the system. It is recommended that schools retain the original card and *prepare a duplicate* to accompany the pupil's scholastic records when the pupil withdraws from the school system to transfer to another school system. The duplicate, however, should be sent to the school receiving the pupil and not given to the pupil to deliver.
8. Report to parents preferably through personal conference or by use of the card, "Report to Parent of Health Inspection".
9. Report to the county superintendent on the card provided for such purpose.

B. Serve as coordinator

1. Make it possible for all specialized workers to give the best possible professional service to the pupils
   a. Examining physician.
   b. Public health nurse.
   c. Child guidance conference.
   d. Crippled children's conference.
   e. Handicapped children's program personnel.
2. Provide a plan by which the Health Record Card may be used where needed in various activities or programs.

II. The Classroom Teacher's Participation

The Health Record Card is the teacher's card to be used and filed in the classroom. It is the only Health Record Card for which the teacher is responsible. It replaces the "Pupil's Health Inspection Record", and makes is unnecessary to transfer health data to other records.

A. Mechanics of using the card

The mechanics of using the card are simple. The card should be handled with uniformity by all teachers, since it will follow the child through his entire school life. Instructions as to the completion of requested items will be found in subsequent paragraphs under the proper headings. The following suggestions will facilitate the use of the card:

1. Each pupil should have a card.
2. The teacher should fill in data under specified headings
   a. At any time she observes something that she wants recorded, either for her use or for reference to the parent, nurse, or physician.
   b. At the time of special activities such as vision testing, weighing, and measuring.
3. The teacher should file the card *in the classroom* during the school year. Provide a definite file, either an improvised box or regular standard file. Have a definite place for the file which is convenient for daily use by the teacher and for use by the nurse.

4. The teacher should mark with a paper clip the card belonging to the pupil whom he wants to refer to the nurse, parent, or physician. This avoids forgetting to refer a pupil.
5. When starting the first card for a pupil, pertinent data from previous records should be transcribed by the teacher.
6. At the close of the school year, or when a pupil transfers from grade to grade, or school to school, the card is transferred with his scholastic records by the school administrator.

B. Teacher observation

This is one of the most valuable contributions in the entire program. Throughout the school day, for days in succession, during many types of activities involving different skills and relationships, the teacher has the opportunity to observe the pupil, to note his behavior and changes in appearance.

1. Recording observations
   a. Use the code for recording observations.
   b. Use the column, "Teacher's Statement of Pupil's Health", for recording explanations of items marked on the reverse side of the card, and for any other statements considered pertinent.
2. Value and use of recorded observations
   a. Basis for teacher-nurse conference—sharing information.
   b. Basis for understanding the pupil.
   c. Basis for planning for the welfare of the pupil on the part of the parent, teacher, nurse, and physician.

C. Annual inspection by the teacher*

The annual inspection by the teacher is required by law in Section 35-3301, Oregon School Laws, 1937 (111-2911, OCLA).

1. Purposes of the annual inspection are
   a. Find defects of "vision, hearing, breathing, dentition, and other external obvious defects which might interfere with the normal education of the child".

* See Health Services for the School-Age Child. Publications of Oregon State Joint Committee for Health and Physical Fitness. Vol. 1, No. 1, 1944.

b. Furnish valuable data for teacher-nurse conference, and for screening purposes.

c. Give a basis for interpreting pupil behavior.

d. Give a basis for observing any changes which may occur.

2. When given

a. As early in the school year as possible.

b. At any time that the teacher observes signs indicating a departure from the average for any pupil.

3. Recording results of preliminary testing

a. Use the code.

b. Additional information is given under proper headings in the manual.

D. Daily inspection by the teacher*

Purpose of daily inspection

a. To detect incipient communicable disease.

b. To protect the school population.

c. To educate the pupil about communicable disease and his responsibility to himself and to others.

d. To emphasize the importance of the parent keeping the pupil at home when he is ill until such time as he is ready to attend school.

The daily inspection should be supplemented by observation of the pupil throughout the school day.

III. The Public Health Nurse's Participation

A. Schedule

1. Arrange a definite schedule for each school.
2. Maintain the schedule.
3. Notify the school administrator if an emergency necessitates a change in schedule.

* See Health Services for the School-Age Child. Publications of Oregon State Joint Committee for Health and Physical Fitness. Vol. 1, No. 1, 1944.

B. Demonstrations

Many teachers request a demonstration of the various tests explained in the manual. These include

1. Inspection by the teacher—daily and annual.
2. Vision testing.
3. Hearing testing.
4. Teeth and mouth inspection.

C. Home visits

D. Conferences

E. Supplying supplementary informational material

F. Recording information

The important thing is to see that the information is properly recorded. The nurse and the teacher should work out a plan by which this is accomplished. The nurse is responsible for certain information which she alone can secure from the

1. Home
2. Physician—recommendations and advice
3. Follow-up — corrections and what has actually taken place.

G. Interpreting information to teachers

IV. The Examining Physician's Participation

The physician examines the pupils who are referred to him following the teacher-nurse conference. He may have his own medical record, but it is his responsibility to record or have recorded on the School Health Record Card the advice and recommendations in which the teacher is interested and about which she can do something.

It is especially desirable for the parent to be present for the examination of the younger pupils. The invitation to parents to be present for the examination usually goes from the school principal's office.

The physician, during the examination, has opportunity for educating the parent and the pupil in matters pertaining to the health of the individual pupil.

THE TEACHER-NURSE CONFERENCE

The teacher-nurse conference is for the purpose of selecting from the entire school system those pupils who appear to need immediate attention of some kind. The teacher has before her the Health Record Card with as much data as she has been able to assemble from her preliminary tests and observations. The nurse may have information from the pupil's pre-school health department records and information which she has secured from the home. Through sharing information it is possible for the teacher and nurse to work out the first steps in planning for the welfare of the pupil. They decide jointly whether the pupil

1. Should be referred to a physician for a health examination.
2. Should be referred to a physician for an opinion.
3. Should be further observed by the teacher.
4. Should have adjustments made in his home or school routine.
5. Should have special instruction pertaining to his health.
6. Should be referred to the Superintendent of Public Instruction for consideration under the program for education of handicapped children.*

During the conference it should be decided *"who is to do what"*. Is the teacher or nurse going to interview the parent? Is the teacher or nurse going to make further tests for the pupil? ***The plan must be definite.***

The teacher-nurse conference makes it possible for a real partnership to function. It provides the teacher with an opportunity

1. To hear the interpretations of the medical findings.
2. To learn about the special needs of individual pupils.
3. To learn about the progress of the follow-up—beginning with the teacher's original observations and tests.
4. To learn more about the pupil's relationship and problems outside the school.

Not all pupils will need this attention. The teacher makes the first selection of pupils for the teacher-nurse conference.

The school administrator in cooperation with the health department arranges for a definite *time* and *place* for a teacher-nurse conference in order to go over the cards of the individual pupils.

It would be of value to the two departments to plan regular group meetings for the purpose of

1. Understanding each other.
2. Demonstrating procedures for the teacher.
3. Evaluating progress.

* See HC Bulletin 2, Information Concerning Certification of Handicapped Children, and HC Bulletin 3, Information About the Education of Handicapped Children. These may be secured from the county school superintendents.

VISION AND HEARING

An Oregon state law requires the testing of all pupils for vision and hearing defects as soon as possible after the opening of each school year.

I. Suggested Times for Testing

A. Annually

Annual tests are necessary to observe changes in vision and hearing of former pupils; and the sensory acuity of new and beginning pupils.

B. At any time deviation from average is noted

1. Whenever a child manifests certain difficulties, hearing, vision, or other defects may be suspected.
2. Vision should be tested following eye injury, acute communicable disease, or serious illness.
3. Hearing should be tested following absence involving earache, ear discharge, or acute infectious disease.

II. Methods of Recording Vision and Hearing Tests or Symptoms

A. Record vision test for right and left eye in fractions

B. Use section on "Eyes" (on reverse of card) with appropriate coding for observation of

1. Sties or crusted lids.
2. Inflamed eyes.
3. Crossed eyes.
4. Frequent headaches.
5. Squinting at book or blackboard.

C. Record hearing in terms of percent of loss when audiometer test indicates it.

D. Use section on "Ears" (reverse of card) with appropriate coding for observation of

1. Discharge from ears.
2. Earaches.
3. Failure to hear questions.

III. Instructions for Hearing Testing

Hearing tests not only enable the teacher to detect potential or genuine hearing losses but also point out *possible* relationships between schoolroom failure and physical handicaps.

Many first-grade children begin school with a hearing handicap; others acquire deficiencies in hearing within their first year of school. Early detection and prompt medical treatment will restore the hearing of many children and prevent the necessity of extreme schoolroom adjustments because of a handicap. If the loss is found to be permanent, the teachers from year to year will be informed through the record on the card and will adjust their instructions accordingly.

The hearing of children varies from time to time. A satisfactory hearing score in September does not necessarily indicate that the child will have perfect hearing throughout the school year. He may be seriously handicapped as soon as he gets a cold, has discharging ears, or has ear-involvement from an infectious disease. Consequently the teacher must be ever alert to signs which may indicate the presence of a hearing deficiency.

Hearing tests may be given by audiometers, or by voice. The audiometer is more accurate than any other method because it records the hearing loss in graduated scales of loudness. Tests by phonograph audiometer can be given to groups of 40 at a time at the rate of 120 an hour. It serves to screen out the deficient pupils who are later retested by the pure-tone audiometer, a very precise instrument. If the tests are given under standardized, controlled conditions by a properly trained technician, it is safe to assume that the children's hearing was satisfactorily measured at the time of the tests. A child who fails two group tests and a pure-tone audiometer test needs examination for pathology by a physician. The Oregon State Board of Health furnishes audiometer testing services to the county health departments. The latter make arrangements for scheduling tests with the superintendent of the local schools. Inasmuch as these tests are given under rigid, standardized conditions, it is necessary that complete preparations be made in advance so that principals and teachers will be informed of the procedures necessary for the satisfactory conduct of the tests. Results of the tests should be given to the principal who confers with the teacher and nurse regarding special problems of each hard-of-hearing

child. The nurse should make home calls to discuss plans with parents. The local superintendent may make application to the State Department of Education for special aid for those with handicapping hearing deficiencies.

What tests can the teacher administer that will give him an understanding of the pupils' hearing? One test that requires very little time and is helpful in locating pupils with a hearing loss is the whisper test.

A. Whisper test

The whisper test is administered to all the pupils in the classroom at the same time. The children remain at their respective desks and face the front all the time the test is being given. The reason for this is to make it as near the normal procedure and environment in the classroom as possible.

Below is an outline of the procedure to follow in giving this test:

1. Each pupil should have a piece of paper and a pencil.
2. Have the pupil mark off the paper into four columns. At the top of the first column put, "Front"; second column, "Left Side"; third column, "Back"; and the fourth column, "Right Side".
3. Explain to the pupils that you will whisper four numbers from 1-10 to be written in each column. The first group of four numbers you will give from the front of the classroom; the second group from the left side of the room; the third group from the back; and the last group from the right side.
4. Explain to the pupils that they are to write down the numbers in the column corresponding to your position in the classroom.
5. Tester should have arranged her groups of numbers before she starts to administer the test, for example:

Front	L. Side	Back	R. Side
2	3	5	10
5	8	1	2
1	6	9	5
4	10	3	3

6. Tester should stand in front of the room, cover her face with a book and whisper the numbers individually that have been selected to give from that position. Allow the pupils enough time to write the first number down before giving the next. The reason for the holding of a book in front of the face is so pupils will not have a chance to lip-read.
7. Next the tester goes to the left side of the classroom and whispers the four numbers selected to be given for that position.
8. Follow the same procedure and give the numbers from the back of the room and then from the right side of the room.
9. Collect the papers and check against the chart.

B. Interpretation of results

The results cannot be converted into any elaborate calculations but can be interpreted to determine whether or not the pupils heard from the four positions in the classroom.

If a pupil seated near the back failed to hear the first group of numbers given from the front but heard all of them when the teacher was at the back of the room, then it is wise to place that child near the front of the classroom.

If a child seated near the right side of the room got all the numbers correct when the teacher was on that side but couldn't get the group of numbers given from the left side, then perhaps he would profit by being placed near the front.

Check further with the pupils that missed several of the numbers and endeavor to find out in which ear they have the most hearing. If a child has more hearing in one ear than the other, then place him in the front to one side so his better ear will be toward most of the pupils. Sometimes the child's hearing loss seems to be about the same in both ears, then it is wise to place him in the center-front of the room.

C. Test to use with children who are too young to write

Arrange the children in a circle around the classroom facing the wall. The tester should stand in the middle of

this circle where she will administer the test. If there are too many youngsters in the class, it is wise to test smaller groups.

Explain to the pupils that their hearing is going to be tested. Whisper their names and instruct the children that when a child hears his own name he should raise his right hand. After a child's name is whispered, he must listen because several numbers between 1 and 10 will be given individually and he is to repeat each number.

It is wise for the teacher to keep a record of each child's response to refer to when the test is completed.

The pupils who seem to have a hearing loss should be placed in the classroom in the same manner as explained with the group who wrote down the numbers.

The purpose of this simple test is to give the teacher an idea which of the children can hear her and which cannot and then to place the children with a loss in hearing in the most advantageous place in the classroom.

IV. Clues to Deficient Hearing

The teacher should familiarize herself with certain clues which often indicate the presence of deficient hearing and which may not be otherwise discovered except by formal, periodic tests of all pupils. Keeping in mind these clues she should suspect the presence of hearing loss. She should always consider the possibility that a "slow" child may have a physical handicap. The following clues may enable her to select the children who should be referred to the public health nurse:

A. Physical clues

Earaches, discharging ears, keeping cotton in ears, ringing or buzzing sounds when all is quiet, speech defects—especially s, z, t, sh, ch, k, voice and vowel defects, and absence on account of ear troubles.

B. Behavior clues

1. Failure to carry out instructions by
   a. Making repeated mistakes.
   b. Responding slowly.
   c. Observing others before beginning work.

2. Frequent requests for repetition of spelling and dictation.
3. Inattention in oral activities.
4. Failure to participate in class discussion.
5. Turning one ear to speaker or leaning forward.
6. Showing tension, strain, or confusion when listening.

C. Scholastic clues

1. Repeating grades.
2. Not achieving maximum intellectual possibilities.
3. Excellence in manual activities and poor work in verbal studies.

D. Some abnormal behavior patterns *may be attributed* either to visual or hearing defects or both

1. Frequent crying.
2. Frequent fits of temper.
3. Inattention at reading lessons.
4. Spending time in reading which should be spent at play.
5. Exhaustion or irritation before day is half over.
6. Peculiar personality traits, such as extreme timidity, sensitivity, or recessiveness.
7. Marked change after return from sickness.

Whenever any of these clues are pronounced in a child, he should be given immediately a vision and hearing test. If he is deficient, make a check mark in the test section and a notation in the observation section of the health card. Refer the child to the public health nurse upon her next visit.

V. Instructions for Vision Testing

Vision tests of all children are made as soon as possible after the opening of school. They are repeated following an eye injury or a serious illness, especially after an acute communicable disease.

The Snellen test is generally accepted as the best basic test for screening purposes. Although all visual defects are not detected by screening pupils with this chart, many defects are uncovered when the Snellen test is carefully given. Some pupils

who recognize the symbols on the chart may have considerable difficulty in school work. Since the teacher has the opportunity of observing each child from day to day, she is in a position to notice unusual reactions, conditions or changes in behavior.

A. Snellen test for all grades

1. Equipment needed
   a. Snellen test chart, symbol E, approved by your health department may be obtained from the county school superintendent.
   b. Window card which shows only one symbol at a time, thus focusing the child's attention and preventing memorization.
   c. Small cards or folded clean paper for covering one eye at a time, one for each child, to be destroyed after one use.
   d. Tape measure or yardstick for measuring 20-foot distance. The test is made at this distance because rays of light from objects approximately 20 feet away are parallel at the eye and the eye is at rest when looking at objects 20 feet away. Chalk to mark floor.
   e. Lightmeter for measuring light on chart; may be borrowed from a light company or from the health department. One may be purchased from the General Electric Company, Cleveland, Ohio, for $12.

2. Care of testing equipment
   Keep the testing cards and symbol E chart and cover card in the back of your register. Paste a three-inch strip of paper along the end of the inside back cover, leaving the inner edge open to receive and hold the testing cards. *Do not leave the symbol E chart hanging on the wall* at times other than when testing.

3. Directions for testing
   a. Explain to the class the nature of the test. Draw the E symbol on a card or on the board. Show the E in different positions and explain to the children that they are to indicate with their hands the direction in which the limbs point.

b. Find the wall surface most free from glare and hang the chart with the 20/20 line at the child's eye level, according to whether he is to stand or sit. The light should be evenly distributed over the chart and should be between 8 and 12 foot-candles. The illumination in the room should be not less than one-fifth of that on the chart. A lightmeter is used if possible to determine the lighting conditions. The principal of the building or the public health nurse should select a place which answers these requirements and instruct all teachers to use this space, maintaining the same conditions of lighting.

c. Seat the child so that his eye is at a distance of 20 feet from the chart. It may be necessary at first to stand the child closer to the chart to explain the testing procedure.

d. The child's confidence and cooperation are necessary. Privacy and quiet are essential.

e. Explain again to the child how he is to point the direction of the limbs of the symbol. Encourage him to do his best but avoid permitting him to strain.

4. Procedure

a. If the child wears glasses, test first with glasses then without. Test both eyes together first then the right and left. Record in the same order.

b. Give him a card to cover his eye. Have him place it obliquely across the nose and keep the covered eye open. An older pupil may hold the card for the younger children, *but the teacher should give the preliminary test.*

c. Ordinarily begin with the 50-foot line and proceed with the test to include the 15-foot line. If a child is suspected of low vision, begin at the top of the chart. This may be necessary with the younger pupils.

d. As a final precaution point to the 10-foot line and ask the child, "Can you tell me which way any of these figures point?"

e. Use the window card to expose one symbol at a time. Show one vertical and one horizontal symbol on a line and move to the next smaller line. Move promptly and rhythmically from one symbol to another in accordance with the speed of the child's response.

f. Watch carefully the child's actions and note scowling, tilting head, eyes watering, excessive blinking, and record these with the test results under "Remarks".

g. In the last line which is read correctly show all four symbols. Successful reading of three out of four is evidence of satisfactory vision at that level.

5. Record of findings

Results of the Snellen test are recorded as if they were a fraction.* Record visual acuity in order given ("with glasses": "right eye", "left eye"; "without glasses": "right eye", "left eye", "both eyes").

Numerator=distance from chart=20 feet.

Denominator=last line read (3 out of 4 symbols)=e. g. 20, 30, 40.

Examples: 20/20 means that the child sees at 20 feet what he should see at 20 feet and has normal vision. 20/70 means he can read at only 20 feet what he should see at 70 feet.

If the testing chart has no symbols larger than 20 70 and a child does not pass at 20/70, indicate the failure by placing a minus (—) sign after the 20/70, thus 20/70—.

6. Referral

Whenever the vision in either eye is found to be defective (20/40, 20/50, 20/70, or greater loss), the teacher will notify the parent or guardian on one of the notice cards as required by law. Children whose behavior and complaints indicate possible visual disturbances are referred to a parent even if they have 20 20 vision. It is not expected that all visual disturbances will be found by the use of the Snellen chart alone, but the Snellen chart plus close observation and a careful history should indicate the children in need of medical examination for their eyes.

The teacher will also give the names of the children so referred to the public health nurse upon her next visit to the school. The latter will assist and advise in the matter of referral of these as well as any doubtful

* This should not be interpreted as percent of vision. 20 30 visual acuity is not $^2/_3$ or 66 percent vision but actually represents 91.4 visual efficiency.

cases. Among the doubtful cases should be pupils who read satisfactorily at the 15 15 or 15/10 or 20 30 lines.

Corrections: In securing corrections for eye difficulties, it is well to recognize first that glasses may not be necessary or desirable. It is very important to obtain from the physician a definite diagnosis and recommendations as to: (1) how glasses should be used, (2) modification of school activities if needed, (3) when the child is due for reexamination.

7. Remove the symbol E chart, after the test is over, from the wall and return it to the back of the register with the cover card.

VI. Clues to Deficient Vision

The following clues may be used to warrant further investigation of the child's visual condition:

A. Physical clues

Red eyes, red eyelids, crusts on lids, sties, swollen lids, watery eyes, tears, report by child of chronic headache (and nausea), dizziness, blurring of vision, and sensitivity to light.

B. Behavior clues

1. Attempts to brush away blur; rubs his eyes frequently.
2. Blinks continually when reading.
3. Holds the book either too far way from or too close to eyes when reading; tilts head to one side.
4. Holds his body tense or thrusts his head forward when looking at distant objects.
5. Inattentive in wall chart, map, or blackboard lesson.
6. Irritable over work.
7. Reads but a brief period without stopping.
8. Screws up his face when reading or looking at distant objects.
9. Shuts or covers one eye when reading.
10. Poor alignment in penmanship.
11. Reversal tendencies in reading.
12. Confusions in reading and spelling: o's and s's; e's and c's; n's and m's; h's, n's and r's; f's and t's.

C. Scholastic clues

1. Repeating grades.
2. Not achieving intellectual possibilities.
3. Excellent in oral and low in reading, writing and drawing activities.

DENTAL EXAMINATION

I. Elementary Grades

A. This examination by the teacher is of necessity a cursory one, and it is not meant to replace regular periodic examinations by the dentist. It serves to inform the teacher of very obvious dental defects which should be recorded in the proper column. *Do not send a written notice to the parents* informing them of the dental defects, for it is better to point out to the child in a mirror what you think to be a defect. The child should be instructed to then show the parent who may go to the family dentist or may come to school to discuss the problem with the teacher.

B. Whenever a child has any of the following which are deviations from a normal healthy mouth, it should be recorded in the column under "teeth" using appropriate code.

1. Unclean, stained teeth.
2. Highly reddened gums which appear flabby or puffed.
3. Very irregular teeth, particularly protruding upper teeth.
4. Speech defects which may be associated with irregular teeth or other abnormal conditions in oral cavity.
5. Marked swelling inside mouth around teeth.
6. Broken down roots and loose teeth.
7. Acute or chronic toothache.
8. Chronic unpleasant breath.
9. Any sore inside mouth on tongue or on lips which does not heal in 10 days or 2 weeks should be carefully observed and reported to the nurse.
10. Dental cavities in either first or second teeth.

C. The teacher should make observations concerning dental needs irrespective of dental examinations by a dentist which are usually made later in the school year.

D. The teacher should exclude a child from school because of suspected mouth infections only on the authority of a dentist or physician.

E. The teacher fulfills her obligation in the dental field when she examines a student and records her observations. She must avoid making a definite statement or a dental diagnosis. The statements "there seems to be", or "it appears", in discussing findings with the student or parent are preferable.

F. Teacher examination is much more effective if dental health class discussions and dental projects are used as a part of regular teaching. Urging students with known dental defects to go to the family dentist for correction in order to safeguard and improve health and appearance is the purpose of dental examinations.

G. When dental corrections are made they should be promptly recorded in proper space on the school health card.

II. High School

A. A well-balanced dental health program places major emphasis on frequent examination and remedial dental service for pre-school and elementary school ages as an integral part of the school health program. The high school students' dental problems are also very important. This plan should simply be a continuation of the pre-school and elementary dental program but along different lines.

B. The advantages and necessity of periodic dental examinations and dental corrections for high school students, in the office of the family dentist, should be shown by precept and teaching.

C. Dentists in every part of Oregon have agreed to do free dental examinations in their own offices for high school students who present a properly signed referral card from the school. (These cards are furnished to schools by request to the Oregon State Board of Health, Oral Health Program, Portland.)

D. The responsibility of securing these free examinations and corrections is placed on the student. Experience has shown that most of these students, after having the opportunity of talking with the dentist in his office and discovering their dental needs, will in many cases make every effort to have necessary dental work completed and will find a method of paying for it. Except in unusual cases, the school administrator need not be concerned about obtaining funds to aid students for dental care.

E. The high school administrator's part in this program is, therefore, to plan for these examinations early in the school year.

F. The responsibility of planning for and conducting the high school dental program should be placed on the school health committee in large schools and a special teacher in small high schools.

G. The student, as a part of the regular high school program, should be given the responsibility for making and keeping the appointment with his family dentist.

H. The student should return the referral card to the teacher in charge as soon as the dental examination is completed.

I. The student should notify the teacher by presenting the card signed by the dentist when dental work is complete. Proper notation should be made on the School Health Record Card.

J. This procedure should be a regular part of the school health program and the student should have at least one dental check-up and the necessary dental service completed each year.

K. The Dental Consultant, Oregon State Board of Health, will aid in the plan when requested.

IMMUNIZATION AND TESTS

The immunization of any child is a parent and family responsibility. The immunization program in school should be a follow-up or rechecking service. Diphtheria and whooping cough immunizations should have been done soon after the sixth month of age; smallpox vaccination, before the end of the infant's first year. Only skin testing to determine immunity and revaccination should be necessary in school.

I. Recording

When the card is first used refer to past records or to the nurse for information.

1. Code immunization and test record in the block under "Immunization".
2. Code communicable diseases which the child has had, with the date (calendar year) as
   a. Smallpox vaccination—Sm. pox, date
   b. Diphtheria immunization or diphtheria—Dip. Im., or Dip., date
   c. Test for tuberculosis, negative or positive—Tbc. T., (—) or (+), date
   d. X-ray for tuberculosis, negative or positive—Tbc. T. XR (—) or (+), date
   e. Measles—Meas., date
   f. Chickenpox—Ch. pox, date
   g. Whooping cough—Wh. C., date
   h. "Others" may include immunizations for typhoid, scarlet fever, etc.
3. Follow instructions of physician for care of vaccination.
4. Refer unusual conditions to the nurse.
5. If necessary, use additional blocks in recording disease history only and a bracket to indicate a specific semester or term.
6. Have displayed in each classroom a copy of "Important Information About Communicable Diseases" distributed by the county health department. These are rules and regulations of the State Board of Health, revised May, 1943.

TEACHER'S STATEMENT OF PUPIL'S HEALTH STATUS

In this column record additional information not provided for elsewhere on the card. This may include a summary, explanation, or amplification of items coded on reverse side of card. This is the only space where narrative recording will be done. Such notations should be initialed or signed by the teacher making the observation. At the conclusion of each term or semester the teacher making the observations should sign her name in this column. All other recording may be handled by means of the specified code.

If there is a testing program, indicate grade level—results of any psychometric test, group or individual, showing mental retardation and special reading difficulties.

PHYSICIAN'S RECOMMENDATIONS AND NURSE'S REPORT

In this space the nurse records interpretation of findings and recommendations of the examining physician (family physician or health officer) in terms which the teacher can understand. The teacher wants to know what is to be done.

The teacher wants to know status of follow-up by the nurse observation. The nurse records in this section pertinent information regarding home visits, or other data of value to the teacher.

NAME OF FAMILY PHYSICIAN

The name of family physician may be obtained from parents. A policy for referral to a family physician named by the parent should be worked out for emergency calls and for reporting findings of school physical examination.

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